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NEW Ph.D'S

Teresa Graedon received her Ph.D. from the University of Michigan in January. Her dissertation is titled "Health and Nutritional Status in an Urban Community of Southern Mexico." Her research was conducted in the city of Oaxaca, Mexico, in 1973-74. She is currently Assistant Professor of Anthropology in the Duke University School of Nursing, with an adjunct appointment in the Department of Anthropology.

In February, *Gail Hongladarom* received her Ph.D. in Anthropology from the University of Washington. Her dissertation is entitled "Health Seeking Within the Health Food Movement."

Linda Amy Kimball received her Ph.D. from Ohio State University in August 1975. Her dissertation, titled "The Enculturation of Aggression in Brunei Malay Culture," is based on two years' fieldwork conducted in Brunei, Borneo. She is currently writing a book tentatively titled *Dukun, the Principles and Practice of Brunei Malay Indigenous Medicine.* After a general introduction to the Brunei Malay setting and culture, the book gives a detailed description of the medical knowledge customarily imparted to a student in the course of formal oral instruction and guided observation of village medical practice. The author gathered this information during the course of her fieldwork. Her main interests are: indigenous medical systems as seen by their practitioners; the practical uses of such knowledge, including the recognition and delineation of types of ill health, prevention, treatment, and prognosis as understood and utilized by the practitioner; and indigenous observations, medicaments, and treatments which might be of benefit in Western medicine. She has published on language acquisition in childhood of Brunei Malay including the effect the presence of a speech defective child had on normal children, and has a strong interest in the application of anthropological knowledge to improving agriculture. She is presently job-hunting and book writing, and would welcome communication from anyone interested in the areas mentioned above. Her address is 542 Acorn Dr., Dayton, OH 45419.

CORRESPONDING EDITORS

The best way to cover news of a specialized subfield of medical anthropology in the absence of a paid staff of reporters is to have an individual member of the SMA assume the responsibility of covering the subfield in question. Hence the *Newsletter*'s policy of having corresponding editors for several subfields, whose inputs appear in the Specialists' Reports column. Readers whose specialty has not been covered adequately in the *Newsletter* would do well to help us find a corresponding editor for that specialty. Said corresponding editor should be someone with deep knowledge of the specialty, and a commitment to the goals of the Society. Needless to say, the longer a correspondent stays with his job, the better.

ARTICLE

Medical Anthropology and International Health Planning

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Professor Foster originally delivered this paper at a health planning workshop sponsored by the Agency for International Development. While we reported on this workshop in our last issue, we believe that, because of the timely nature of the items considered there, greater coverage should be afforded it. It is our hope that other presentations at the AID workshop will appear in the next several issues of M.A.N. We thank the Agency for International Development for granting us permission to publish this paper.—Eds.

Introduction

On a number of occasions and in various settings during the last generation the Agency for International Development (and predecessor organizations) has brought together health personnel and behavioral scientists to explore the ways in which knowledge about the social organization and cultural forms of "target" groups, the recipients of health services, can assist in the planning and operation of these services. As early as 1951 the Institute of Inter-American Affairs contracted with the Smithsonian Institution for behavioral science assistance in a six-month long team evaluation of the first ten years of United States-assisted health programs in Latin America (Anonymous 1953; Servicio 1953). Subsequently the "Health Advisory Committee" of the Foreign Operations Administration included behavioral scientists as well as medical and administrative personnel. Over the years many formal and informal meetings have been held, all concerned with the problem that brings us together today: the ways in which knowledge of the social, cultural, and psychological factors in traditional societies that influence change can be used to improve health service planning and operations, including the search for new ways to make the most efficient use of scarce health resources.

A Sequence of Premises

While it may seem discouraging that the interrelationships between sociocultural and medical-health behavior phenomena are in danger of being rehashed once more, the terms of reference for this meeting are challenging in that they reflect a broader and more flexible approach to the basic problems than has been found in many earlier conferences. In order better to appreciate this flexibility it will be helpful briefly to review the changing premises, the underlying assumptions, that have characterized American-aided health programs in developing countries. Three major premises have appeared in chronological order:

(1) *The institutional forms and clinical practices of the medical systems of technologically-advanced nations are the appropriate models for the development of health services in all countries.* In early American attempts to help developing countries provide better health services for their citizens, program planners and field personnel operated on the basis of two seemingly obvious (to them) assumptions: First, the best and most advanced American preventive and curative medical

practices, *and* the institutional framework that provides these services, are absolutes that work equally well in all socio-cultural and economic settings; and, second, the people in developing countries will immediately perceive the advantages accruing to them if they give up old medical practices and adopt new ones. (One wonders if smallpox immunization was taken as the universal model, for here indeed is a medical technique whose efficacy does not depend on culture; willingness to be vaccinated is, of course, another matter, and that *does* depend on cultural factors.)

These ethnocentric assumptions represented the prevailing view that American civilization was superior in all ways to other societies, and that given the opportunity people in "less fortunate" countries would clamor to adopt our ways. In the past, Western medical personnel have been, if anything, even more ethnocentric than the general public about the superiority of scientific medicine in all its ramifications, finding it difficult to believe that all peoples would not quickly accept it. Consequently, early workers in international health programs saw their task in simplistic, easily definable terms: transplant the American models, and health goals will be achieved. This philosophy underlay the work of the Rockefeller Foundation in its attempts to eradicate hookworm in Ceylon, 1916-22, and it was implicit in much of the work of the Institute of Inter-American Affairs beginning in 1942. Even today more than a few traces of this point of view are found in international health programs.

(2) *Medical and public health programs in developing countries will be more successful if in design and operation they take into consideration the social, cultural, and psychological characteristics of the target group.* By about 1950, American international health specialists began to realize that the successful delivery of improved health services required more than the silver platter approach. They began to appreciate that modernization is a social as well as a technological phenomenon, and that the people who modernize have cultures and values that strongly influence their decisions in accepting or rejecting innovation. Small numbers of anthropologists came into international public health during the years following 1950, and they played an important role in promoting the "human factors in technological development" point of view, which postulates that the major problems in the development of traditional communities (including health services) are embedded in the society and culture of the target group. These people, it was now assumed, are anxious to enjoy better health, and they are willing to change their health behavior if they understand better the advantages in new ways. If the cultural, social, and psychological "barriers" that inhibit acceptance of new health programs could be identified, it was reasoned, health programs could be designed and presented in ways that conform to cultural expectations. Recognition of the importance of understanding sociocultural factors in designing and carrying out health programs represented a great step forward, and much progress has been made in the delivery of health services as a consequence of this awareness. Still, the fact that we are assembled here indicates that this assumption alone, valid as far as it goes, is insufficient to the task.

(3) *The most successful medical and public health programs in developing countries require knowledge about the social, cultural and psychological factors inherent in the innovating organizations and their professional personnel.* In other words, major "barriers" to improved health programs

also are found in the cultures of bureaucracies, the assumptions of the medical profession, and in the psychological makeup of the specialists who participate in these programs. This assumption, regrettably, appears not to be widely accepted; it is, in fact, stoutly resisted by many. The second premise—that the principal barriers are in the target group—was easily accepted by international health personnel. It seemed to offer quick and easy answers to many problems that had seemed insoluble, and it defined the problem as "out there," among the people who were to be helped. The implications of premise three are, however, disquieting; it is much harder to point the finger at oneself and say, "A lot of the difficulty is right here."

Nevertheless, I am increasingly struck by the fact that many of the apparent resistances to acceptance of health services commonly attributed to villagers' apathy and their cultural barriers, are, in fact, the result of administrative and professional inadequacies. International health programs made significant strides when the importance of social, cultural and psychological factors in target group cultures was recognized. The next opportunity for comparable progress lies, first, in recognizing (or admitting) the limitations in present bureaucratic forms, and in many professional and individual assumptions found in all health programs; and second, in being willing to face up to these problems, even at the cost of professional discomfort.

Innovation in Health Behavior

Let us now ask a pair of questions that stem from premises two and three: (1) What have we learned about the sociocultural and psychological factors in traditional populations that enable us better to understand the process of accepting scientific medicine, and that suggest leads in future program planning? and (2) What do we know about health bureaucracies and health personnel, or what must be learned about them, in order to design and carry out more effective health programs?

In early analyses of the sociocultural factors that seemed to inhibit acceptance of scientific medicine by traditional peoples, anthropologists developed an "adversary" model to explain the resistances that occurred. It was postulated that scientific and traditional medicine were locked in battle, each trying to win (or hold on to) the allegiance of the community. The model postulated that traditional peoples divided illness into two categories: those that medical doctors understood and could cure; and those medical doctors did not know about, much less understand, and which therefore they could not treat. Acute, infectious diseases—those yielding to antibiotics—quickly fell into the first category; the medical doctor's competence here was easily demonstrated. Chronic illnesses, those with major psychological components, and those "magical" in nature (e.g., the evil eye)—illnesses marked by vague and shifting symptoms—tended to remain the provenience of the traditional curer. The task of the anthropologist was to help medical personnel find ways to demonstrate the superiority of scientific medicine, which little by little would move the illnesses in this second category into the first one, the illnesses routinely brought to the medical doctor.

This model is not without merit: independently it has been worked out in Latin America, South and southeast Asia, and other places as well. It was through this model that we learned the *pragmatic* quality of traditional reasoning processes, that if

peasant and tribal peoples could *perceive* advantages resulting from changed behavior, they were willing to drop old and cherished beliefs and practices by the wayside. This dichotomous model—illnesses medical doctors can cure, and those they cannot cure—has proven to be simplistic, as will be pointed out a little farther along.

Obviously there are social, cultural, and psychological barriers to the full acceptance of modern medicine that are found in every traditional community. It would be foolish to deny the importance of these factors, examples of which are known to all of us. In parts of Latin America there is great resistance to withdrawal of blood for laboratory analyses, or for blood transfusions, because of the belief that blood is a non-renewable substance, and that a person is weakened permanently by such withdrawals (Adams 1955:446-447). In Africa where the belief in witchcraft is strong, resistance to the use of sanitary latrines has been noted. People are reluctant to concentrate their feces for the convenience of witches who may wish to work their magic on them (Kark 1962:26). In India it has often been reported that villagers are reluctant to vaccinate against smallpox because of the belief that this is a "sacred" disease sent by a Mother Goddess whose will should not be contravened. In other countries, pregnant women have given as their reason for refusing hospital delivery the fear that the placenta will not be given to the family for ritual disposal. All of these, and countless more examples, can be given of real "barriers" to full acceptance of available medical services.

Yet I am increasingly convinced that *economic* and *social costs* are more important in determining the use or nonuse of scientific medicine than is the belief-conflict between traditional and modern medicine. I now believe that the adversary model is appropriate for the initial contact period when traditional peoples for the first time have the alternative of consulting medical doctors. But the evidence is overwhelming that in countries where traditional peoples have had access to modern medicine for a generation or longer, and where this medicine has been of reasonably good quality, the battle has been won, and scientific medicine is the victor.

The first decision-making model to account for choice of medical help, worked out by anthropologists for developing countries, was a three-stage sequence: (1) home remedies, (2) indigenous curer, and (3) the medical doctor, but only after the first two choices failed to produce results. In 1945, this was true in Tzintzuntzan, Mexico, a peasant community I have studied since that date. Today, however, the sequence is the same as that followed by many Americans: (1) home remedy, (2) medical doctor, and (3) indigenous curer (or faith healer in the United States) only after the first two choices fail to produce results.

It may be argued that relatively few countries in the developing world have the resources of Mexico, and that general acceptance of scientific medicine will not come so readily in the rest of the world. Yet the evidence suggests the contrary. In India, Banerji and his colleagues have carried out studies that show the same trend. In a fairly extensive study they were surprised to find

> that the response to the major medical care problems is very much in favour of the western . . . system of medicine, irrespective of social, economic, occupational and regional considerations. *Availability of such services and capacity of patients to meet the expenses are the two major constraining factors* [Banerji 1974:6; emphasis added].

Further, while Banerji found numerous examples of consulting practitioners of indigenous or homeopathic medicine,

> Among those who suffer from major illness, only a very tiny fraction preferentially adopt these practices by *positively rejecting* facilities of the western system of medicine which are more efficacious and which are easily available and accessible to them [1974:7].

The picture is the same in Thailand where, in a major study of doctor-patient relationships, it was found that "The decision to go to a hospital depends less on the gravity of the disease than on financial resources" (Hinderling 1973:74). The same study revealed that, while in rural areas far from hospitals physicians are sometimes seen as a last resort, in cities the order is reversed: "The modern doctor is the first to be consulted, and [only] if he is not successful, one of the quite fashionable [traditional] healers will be called upon" (Boesch 1972:34).

The Basis for Acceptance of Scientific Medicine

We now turn to the motivations and processes underlying innovation in medical practice. The first thing we note is that they are essentially the same as those that underlie innovation in all areas. I suggest that people will change traditional behavior, i.e., innovate:

(1) if they perceive personal economic, social, psychological, health, or other advantages in so doing;

(2) if they perceive change as a realistic possiblity for them;

(3) if the economic costs are within their capabilities;

(4) if the social costs do not outweigh the perceived advantage.

In other words, people are remarkably pragmatic in evaluating and testing new alternatives, including health services. One can almost speak of a cost-benefit mode of analysis. When, on the basis of empirical evidence, traditional peoples see that scientific medicine is more effective than their own, and when they can have scientific medicine on terms they deem acceptable, they happily turn to it. Speaking of the acceptance of curative medicine in Ecuador, Erasmus, many years ago pointed out that, as far as tradition was concerned, "folk beliefs in themselves are offering no resistance to modern medical practices *in so far as those practices may be judged by the folk on an empirical basis*" (Erasmus 1952:418; emphasis added). In contrast Erasmus found that preventive medicine was resisted because its comprehension is essentially theoretical, not lending itself to easy empirical verification.

The evidence clearly indicates that, as far as individual decision making is concerned, curative medical services are embraced much more readily than preventive services. The reason is obvious: the results of scientific curative medicine are much more easily demonstrated than the results of preventive medicine. Few people suffering from yaws or other dangerous infections which have been cut short by an injection of an antibiotic question that this is indeed a miracle medicine much superior to any they have previously known. Cause and effect are easily comprehended when serious illness gives way to no illness in a few hours or days. Cause and effect are less easily seen when, as in the case of immunization and environmental sanitation programs, no disease is followed by no disease. The implications that must be drawn from this evidence is that the traditional American separation of most clinical from most preventive medical measures is, in other parts of the world, counter-productive. Experience suggests that preventive

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measures are more apt to be accepted if they are "blanketed in" with, or sold as a part of a "package deal" along with curative medicine, whose advantages are so much more easily demonstrated.

But, however pragmatic people may be, this quality is of little value unless innovation is seen as a realistic aspiration for the individual. A peasant farmer may be persuaded that hybrid rice sown on a heavily fertilized irrigated field is agriculturally advantageous, but if his marginal lands do not lend themselves to this intensive approach, or if credit facilities are inadequate, his planting practices are unlikely to change. Similarly, changing health practices may be perceived to be desirable but if for any one or combination of reasons a person feels the goal is unrealistic, change motivation will be lacking.

"Free" Services

When traditional peoples attempt to determine whether contemplated changes in their health practices are in fact realistic, economic factors appear to be the most important of all variables. While on the one hand token fees for medical services have often been reported to confer value on these services, and hence may be desirable policy in some situations (e.g., Foster 1973:136-138), most improved medical services for village peoples will have to be provided by the state, at little or no cost to the consumers. Increasingly this is recognized, and more and more "free" services are offered. "Free" services, unfortunately, are often expensive by village standards. Ndeti, for example, in a study of tuberculosis control in Kenya found that the bus fare kept a large number of patients from coming to the clinic (Ndeti 1972:408).

In Indonesia, family planning services, "free" in the strict sense of the word, are sometimes underutilized because of social customs requiring expenditures. Most mothers are interested in birth control only after they have had four or five children. Often they have no one with whom to leave these children so that when, in response to the urging of a family planning worker, they decide to visit a clinic, at least the younger children must trail along. This usually means a bus fare for all. But a trip on a bus is, by definition, an "outing," and on such occasions people buy food snacks, to which Indonesians are much addicted. So a mother with three or four small children may well spend a day's income on a simple visit to the "free" family planning clinic.

Other kinds of costs may also make "free" family planning services prohibitively expensive. In a village near Bandung, in western Java, at the bottom of a steep valley reached only by a poor dirt road, a woman seeking family planning help has to ascend to the health center in a truck or old bus that requires nearly an hour for the five-mile trip, paying 100 rupiahs fare each way. There she finds that, prior to being given pills or fitted with an IUD she must take a pregnancy test, which carries a laboratory fee of 150 rupiahs. The woman is asked to return three days later—again at a cost of 200 rupiahs for transportation—to learn the laboratory results. If the 200 rupiahs lost by absence from work for two days are added in, it costs a woman 750 rupiahs—more than a week's income— simply to find out if she is eligible for family planning. Small wonder that few of these women are interested in this kind of service (author's field notes).

Social Costs

Finally, we must take note of the "social" costs often involved in changing health behavior. A young woman may be convinced that the government health center in or near her village that offers pre- and post-natal care, and delivery services by a doctor and nurse-midwife team, is a more desirable alternative than is delivery with the aid of a village midwife. But if the midwife is her mother's sister, failure to turn to the aunt may be seen as a personal rejection, an act that may cause major family rifts. This kind of a "social" cost is sometimes seen by traditional peoples as too high a price to pay for perceived advantage. Major behavioral changes almost always produce, or require, major restructuring of traditional and valued social relationships. When the "social" costs of this restructuring—the conflict potential—are seen as outweighing the potential advantage, the decision will be against change.

Bureaucracies in Relation to Health Innovation

We now turn to the (frequently) unrecognized barriers to the best possible health services that are inherent in bureaucratic structures and in the premises of their personnel. The term "Bureaucracy" is used here, not in a pejorative sense, but rather to refer to an organization, an administrative structure, whose manifest functions are to meet formally-defined societal needs. As a university professor, I see myself as much a bureaucrat as is a medical adviser sent abroad by AID. My manifest function is to contribute to higher education and research, formally-defined as a societal need.

My argument here is that if we are fully to appreciate the dynamics of the planned change process, in health practices and in all other fields, it is essential to study administrators, planners, and professional specialists as individuals and as members of professions and bureaucracies, in the same ways and for the same reasons that we study traditional societies or any other client group—for bureaucracies and their personnel can be studied in essentially the same fashion as a peasant village or the urban neighborhood served by a public health center. A bureaucracy, in its structural and dynamic aspects, is very much like a "natural" community such as, for example, a peasant village, in that it is a real society with a real culture. And, like a peasant village, most bureaucracies include members of both sexes of widely varying ages, organized in a hierarchy of authority, responsibility, obligations, and functional tasks. Bureaucracies have social structures that define the role relationships and statuses of their members, and they have devices to change these relationships, through promotion, horizontal shifts, by-passing manoeuvers and—rarely— demotion. Like all people in social units, the personnel of bureaucracies, and the bureaucracies themselves, operate on the basis of implicit and explicit assumptions which can be analyzed just as can those assumptions found in natural societies. Many of these assumptions are influential in the planning of developmental programs, as the following examples will show.

A bureaucracy, as we have seen, ostensibly exists to fulfill a need or needs in society; the manifest functions of bureaucracies are expressed in their charters or enabling legislation, and it is expected that they will fulfill these functions, normally defined in terms of a client group. Yet we all know that, in practice, the primary concern of every bureaucracy and of its personnel is the corporate survival and, if possible, the growth of the organization, and the simultaneous protection of the position of staff members. Only when these concerns are taken care of can a bureaucracy turn full

attention to its client group; and on those occasions when corporate or individual survival are threatened, this group may receive short shrift.

A second premise characterizing most bureaucracies is that the convenience of personnel, their likes and dislikes, has priority over the convenience of clients. This is seen particularly clearly in hours of service. I speak from experience: in setting my major university lectures at eight o'clock in the morning I have uppermost in mind my own convenience. I realize this hour is not the choice of most members of my client group, the students, whose needs I am supposed to serve. They would prefer the more popular hour of ten o'clock; and were I to lecture at that time my client group would double. Similarly, hours of service of government offices, including health departments, in this country and in developing countries, are set for the convenience of personnel and not for clients. We have all observed instances where the services of government clinics have been badly underutilized, largely because official hours from eight in the morning until two in the afternoon are the least convenient time for village women. Moreover, frequent failure of health personnel to be available at these stipulated times means that long and expensive trips by patients may be in vain. Such casual attention to the needs and feelings of patients is at least as much a "barrier" to adoption of better health practices as are beliefs in the efficacy of traditional medicine, or the fear of disrupting family relationships by adopting new health customs.

Social Costs of Changes in Bureaucracies

The social cost of bureaucratic flexibility, of responsiveness to changing needs, are at least as great as are the social costs of new behavior in traditional communities. The problem lies in the inevitable changes in role relationships—changes that threaten the position of some of the members of the group—that accompany major restructuring in any society, a bureaucracy included. The societal needs that a major bureaucracy should meet are not static; over time they change and evolve. Innovative programs and pilot projects designed to meet these changing definitions of purpose and need require that new skills and professional specialties be brought into the organization. Simultaneously the talents of some staff members which were of critical importance during an earlier period, or in the context of projects now closed out, may become less essential. To put it briefly, new priorities mean that new roles must be created, and some old roles given added importance, while other old roles diminish in importance, with loss of relative rank, authority, and privilege to the incumbents occupying these latter roles. But, just as the first concern of a bureaucracy is to ensure its survival and to protect itself against inroads from competing organizations, so is the first priority of the professional to protect his or her position within the organization. Like people in "natural" communities, we professionals jealously guard our traditional perquisites and privileges; we do not willingly surrender something except in exchange for something as good or better. All of us, as bureaucrats, rationalize our resistance to change that may leave us in a less desirable position by arguing—and usually genuinely believing—that what is good for us is also best for our institution, and for its clients. Consequently, we may go to extreme lengths, including back-biting, in-fighting, and bickering in effort to protect ourselves. The resulting

social costs—lowered morale and intra-organizational friction—often seem to outweigh the advantages of greater responsiveness to new needs, and consequently most bureaucracies change very slowly.

Medical Role Perceptions as Barriers to Change

The underlying assumptions of medical personnel about their roles, responsibilities, and the structure of medical services sometimes constitute barriers to the development of health services best suited to the needs of developing countries. The traditional American division of health services into preventive and curative fields, for example, which developed in response to a variety of pressures and vested interests inherent in the American way of life, was assumed in early programs to be the "norm" for overseas development. The Rockefeller anti-hookworm campaign in Ceylon was very strictly a preventive program, and field personnel repeatedly were cautioned not to become involved in curative services. Yet one reason the project failed to eradicate hookworm was that to the Ceylonese the rationale of environmental sanitation to the exclusion of *their* health priorities made little sense.

> Some villagers were irritated by the concentration on hookworm disease in view of their other overwhelming medical needs. . . . The villagers were more interested in having their wounds and abscesses dressed and their miscellaneous acute illnesses attended than continuing in the dull routines of anti-hookworm work [Phillips 1955:289].

Despite the home-office warnings not to scatter their energies by engaging in curative activities, field directors found they had to treat all kinds of complaints in order to gain support for the hookworm work.

Institute of Inter-American Affairs programs in Latin America in the 1940s also emphasized prevention rather than curing. This medical assumption has, in the past, proven to be one of the most serious of all barriers in building better health services in developing countries. Fortunately, few if any such countries today are planning their health services on other than a combined basis.

The mode of definition of health problems frequently limits medical organizations in searching for the most efficient ways of meeting health needs. As John Bryant has pointed out, a health problem is what is defined by the medical establishment (headed by medical doctors) as a health problem; consequently health priorities set by "medically qualified" people are the appropriate priorities. In exploring this phenomenon, we find that we are dealing not alone with the traditional wisdom of the medical profession, but also—frequently—with the ego structure of individual specialists. As professionals we are proud of our skills, and we derive satisfaction in demonstrating our competences to ourselves and our colleagues, *and* in having these competences acknowledged. If we are honest with ourselves, we must admit that we crave recognition. Consequently, our ego-needs not infrequently motivate us to search out and concentrate on special problems that are important, not so much to our client group as to ourselves, because of the opportunity they offer to demonstrate to our peers our exceptional capacities. All too often we confuse our psychological needs with the needs of our clients, and we assume that our personal priorities must also be those of the people we serve. In the planning and operation of health programs we must acknowledge that

personal interests—even research hobbies—play an enormously important role in the final form of a service.

Finally, we must note an assumption of many medical doctors that is crucial to one of the main themes of this workshop, the possible role as sub-professional workers of indigenous medical personnel. John Bryant, in *Health and the Developing World*, has put the matter succinctly and sympathetically. A part of the greatness of the good physician, he says, is his acceptance of responsibility to give unstintingly of himself to those who need his help. But this is also the basis for his traditional reluctance to share his activities with others, to relinquish some of his tasks to less thoroughly trained personnel. To admit that many of the professional tasks he has been trained to perform can be carried out equally well by less well trained people apparently threatens the ego of many medical practitioners.

> A curious side of this concept [that only the physician can provide quality care] is the value the physician places on the particular acts of diagnosis and prescription of treatment. Physicians are anxious to use every level of health worker in furthering a health program ... but the words "diagnose" and "prescribe" evoke the strongest feelings of professional possessiveness [Bryant 1969:141-142].

The concept that the physician must attend personally to his patients actually determines the form of most health services, says Bryant, and it can obstruct efforts to change the design of health systems.

> Thus while logic tells us that the physician's role should be determined by the health needs of the entire population, implementation of this logic is obstructed by the insistence of the medical profession that only physicians can evaluate and treat the sick. This stand of the medical profession has a paralyzing effect on the design and implementation of health services and is one of the most serious obstacles to the effective use of limited health resources" [1969:143].

Bryant's warning leads to my final point: possible roles for traditional healers in national health services.

Possible Roles for Traditional Healers

Paradoxically, the growing acceptance of Western medicine is creating a crisis in most developing countries. There are not now, nor will there be in the foreseeable future, sufficient fully-trained health personnel to meet all health needs. Auxiliary health workers have been and will continue to be used in almost all countries. In the former British and French colonies, local men were trained as "dressers" or "*infirmier auxiliaires*" to staff rural clinics and, depending on level of training, to perform a variety of therapeutic duties including simple laboratory analyses. Among the Navaho Indians the "health visitor" works under the supervision of the public health nurse, significantly extending her capacity to fulfill her role. In contemporary China, rural "barefoot doctors" offer a primary level of treatment in a referral system which sends seriously ill patients to more highly trained health personnel.

In these, and in other comparable instances, the sub-professional worker is (or was) a member of the formal health establishment, trained by qualified teachers, and paid by, and formally incorporated into colonial, tribal, or national health services. Because of the relative success of this approach in helping to solve health problems, and in the face of (almost certainly) permanent shortages of highly trained personnel, the question periodically is asked, should indigenous healers also be recognized as having something important to offer? Should they, in some way, be incorporated into the health services of a country? In the development of national health programs based on Western medicine official attitudes toward traditional healers have ranged from neglect to outright opposition: they have been looked upon by most medical doctors as undesirable competitors, if not outright enemies to be vanquished. Only occasionally, as with Ayurvedic medicine in India, has an indigenous medical system and its practitioners been formally encouraged by government. Even in India the vast substratum of "folk" medicine not recognized as Ayurvedic is ignored by the government.

The question of recognition of traditional healers is important because, in addition to the manpower problem, the fact remains that no scientific medical system completely satisfies all health needs of a nation. Even in countries with highly developed health care systems many people, under certain conditions, will turn to non-establishment forms of medical help such as faith healers, herbal doctors and the like. "Alternate" forms of medical care fill social, psychological, and perhaps organic health needs which, at least for some people, remain unmet by physicians and associated care services. With respect to a formal policy, the answers are not easy. Viewing particularly the supportive sociopsychological functions of the indigenous curer, anthropologists have been impressed with the positive aspects of non-Western medicine. Medical doctors, on the other hand, point out that some traditional remedies are definitely dangerous, and that at the very least treatment by traditional curers may delay referral to medical doctors until routine treatment such as an appendectomy becomes vastly more complicated.

Harrison, in discussing the possible role of non-Western medical personnel in Nigeria found that most government personnel were skeptical of their value.

> One government official told me that they are untrainable because of their superstitious beliefs and because their practice is secret and difficult to evaluate. They view the delivery of babies as a supernatural process. Mothers are discouraged from using traditional healers because there are so many quacks among them [Harrison 1974-75:12].

This negative evaluation is reflected in most other countries.

In spite of this prevailing view, successful efforts have been made to incorporate indigenous midwives into formal medical services. Since most births are "normal," it is reasoned, the primary problem is (1) to encourage the midwife to practice hygienic methods and (2) to refer difficult cases to government health services. Since at least the early 1950s village midwives in El Salvador have been recognized and trained by government personnel, and among the Navajo Indians similar training has reduced infant and maternal mortality. More recently there are reports of this kind of training for indigenous midwives in Tanzania (Dunlop 1974-75:138) and Liberia (Dennis 1974-75:23).

Mental illness is a second area in which formal recognition of traditional healers seems potentially promising. Since patient expectation is an important element in therapy, it seems reasonable to expect that in the absence of organic dysfunction mental stress and illness can be alleviated by curers whose treatments have been seen to be successful in the past. Torrey believes that, in spite of the anecdotal nature of the evidence on the efficacy of therapists in other cultures, "It is almost unanimous in suggesting that witchdoctors get about the same therapeutic results as psychiatrists do" (Torrey 1973:119). In Nigeria, Maclean appears favorably impressed

by many aspects of traditional treatment of mental illness, and not the least by rituals enacted to symbolize recovery at the end of a period of treatment. Dressed in the clothing worn during his illness, the patient is taken to a river where a dove is sacrificed over his head, and he is washed in its blood. Then his old clothing is removed and, with the carcass of the bird, thrown into the stream and carried away, while the priest-curer chants:

As the river can never flow backwards,
So may this illness never return.

The former patient now dresses in new clothes and meets his relatives who have assembled for a feast in honor of his newly-recovered health. Both patient and family benefit from this ritual: the former is reassured that his relatives welcome him back to his usual role, while the latter has the priest's assurance that he can be counted on to carry on with his normal activities. This is in striking contrast, says Maclean, to Western society where a former mental patient leaves the hospital with a stigma which may never disappear (Maclean 1971:79-80).

Whatever the potential merit of making formal use of the medical talents of indigenous curers, the idea has made little progress in practice. Perhaps the question will never need to be resolved, for it erroneously assumes that traditional healers will continue to be produced in the same numbers and with the same skills as in the past. But social, economic, and educational change is coming with such speed in all the world that most of tomorrow's traditional healers probably will have been trained in medical schools, schools of nursing, and other government health institutions. Consequently, I suspect that any increase in the formal use of traditional healers in the context of national health services will be at best no more than a transitional step, and that after relatively few years, the question of their possible utility will be moot.

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